Company Tracking Number: TL AR0045615C01

TOI: L041 Individual Life - Term Sub-TOI: L041.003 Single Life - Single Premium

Product Name: Term Life

Project Name/Number: Term Life/TL AR0045615C01

# Filing at a Glance

Company: Stonebridge Life Insurance Company

Product Name: Term Life SERFF Tr Num: AEGX-125987244 State: ArkansasLH TOI: L04I Individual Life - Term SERFF Status: Closed State Tr Num: 41336

Sub-TOI: L04I.003 Single Life - Single Premium Co Tr Num: TL AR0045615C01 State Status: Approved-Closed

Filing Type: Form Co Status: Reviewer(s): Linda Bird

Author: SPI ADMSLH Disposition Date: 01/15/2009

Date Submitted: 01/13/2009 Disposition Status: Approved

Implementation Date Requested: Implementation Date:

State Filing Description:

#### **General Information**

Project Name: Term Life Status of Filing in Domicile:
Project Number: TL AR0045615C01 Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:

Explanation for Combination/Other: Market Type:

Submission Type: New Submission Group Market Size:

Overall Rate Impact: Group Market Type:

Filing Status Changed: 01/15/2009
State Status Changed: 01/15/2009
Deemer Date:

Filing Description:

Stonebridge Life Insurance Company NAIC #65021 FEIN #03-0164230

Corresponding Filing Tracking Number:

Form Filing

FOR: Individual Term Life Insurance Policy - SLTL1400IP

Enrollment Form - SLTL1400IE

Actuarial Memorandum

Company Tracking Number: TL AR0045615C01

TOI: L041 Individual Life - Term Sub-TOI: L041.003 Single Life - Single Premium

Product Name: Term Life

Project Name/Number: Term Life/TL AR0045615C01

The captioned individual term life insurance policy and related material is submitted for your departmental review and approval. This form is new and is not intended to replace any previously approved form.

The Product will not be illustrated.

The policy provides term life insurance. The death benefit is level for a period of 12 consecutive months and pays the face amount in the event of death due to any cause.

The single premium is non-contributory and payable by the entity named in the premium payment provision. The policy is issued on a guaranteed issue basis. Issue ages are 18 - 49.

Bracketed information throughout the Policy is intended to be variable and explained in the attached Explanation of Variability document.

The product will be marketed via direct response means, including mail, telephone solicitation and internet. We intend to use an electronic signature process for the customer's signature of the enrollment form in the telephone and internet channels, and will maintain records of sales of this product in a secure electronic format. We will use enrollment form SLTL1400IE to solicit this product.

# **Company and Contact**

#### **Filing Contact Information**

Cathy Wynn, Filing Specialist cwynn@aegonusa.com 400 Galleria Parkway (678) 402-2085 [Phone] Atlanta, GA 30339 (678) 402-2105[FAX]

**Filing Company Information** 

Stonebridge Life Insurance Company CoCode: 65021 State of Domicile: Vermont 29 South Main Street Group Code: 468 Company Type: Life and Health

Rutland, VT 05701-5014 Group Name: State ID Number:

(410) 685-5500 ext. [Phone] FEIN Number: 03-0164230

SERFF Tracking Number: AEGX-125987244 State: Arkansas

Filing Company: Stonebridge Life Insurance Company State Tracking Number: 41336

Company Tracking Number: TL AR0045615C01

TOI: L041 Individual Life - Term Sub-TOI: L041.003 Single Life - Single Premium

Product Name: Term Life

Project Name/Number: Term Life/TL AR0045615C01

-----

SERFF Tracking Number: AEGX-125987244 State: Arkansas State Tracking Number: 41336

Filing Company: Stonebridge Life Insurance Company

Company Tracking Number: TL AR0045615C01

TOI: L04I Individual Life - Term Sub-TOI: L04I.003 Single Life - Single Premium

Product Name: Term Life

Project Name/Number: Term Life/TL AR0045615C01

# **Filing Fees**

Fee Required? Yes Fee Amount: \$50.00 Retaliatory? Yes

Fee Explanation:

Per Company: No

COMPANY **AMOUNT** DATE PROCESSED TRANSACTION #

Stonebridge Life Insurance Company \$50.00 01/13/2009 25004070

Company Tracking Number: TL AR0045615C01

TOI: L041 Individual Life - Term Sub-TOI: L041.003 Single Life - Single Premium

Product Name: Term Life

Project Name/Number: Term Life/TL AR0045615C01

# **Correspondence Summary**

### **Dispositions**

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	01/15/2009	01/15/2009

Company Tracking Number: TL AR0045615C01

TOI: L041 Individual Life - Term Sub-TOI: L041.003 Single Life - Single Premium

Product Name: Term Life

Project Name/Number: Term Life/TL AR0045615C01

# **Disposition**

Disposition Date: 01/15/2009

Implementation Date:

Status: Approved

Comment:

Company Name:	Overall % Rate	Written Premium	# of Policy	Premium:	Maximum %	Minimum %	Overall %
	Impact:	Change for this	Holders		Change (where	Change (where	Indicated
		Program:	Affected for		required):	required):	Change:
			this				
			Program:				
Stonebridge Life	%	\$		\$	%	%	%
Insurance Company							

Company Tracking Number: TL AR0045615C01

TOI: L041 Individual Life - Term Sub-TOI: L041.003 Single Life - Single Premium

Product Name: Term Life

Project Name/Number: Term Life/TL AR0045615C01

Item Type	Item Name	Item Status	<b>Public Access</b>	
Supporting Document	Application		No	
Supporting Document	Life & Annuity - Acturial Memo		No	
Supporting Document	Explanation of Variability		Yes	
Supporting Document	AR - CONSENT TO SUBMIT RATES  AND/OR COST BASES FOR  APPROVAL, AR - NAIC TRANSMITTAL  DOC, AR - NAIC FORM FILING  ATTACHMENT			
Supporting Document	Flesch Certification		Yes	
Form	Individual 12-Month Term Life Policy		Yes	
Form	Enrollment Form		Yes	

Company Tracking Number: TL AR0045615C01

TOI: L041 Individual Life - Term Sub-TOI: L041.003 Single Life - Single Premium

Product Name: Term Life

Project Name/Number: Term Life/TL AR0045615C01

## Form Schedule

#### **Lead Form Number:**

Review	Form	Form Type Form Name	Action	Action Specific	Readability	Attachment
Status	Number			Data		
	SLTL1400I	Policy/Cont Individual 12-Month	Initial		59	SLTL1400IP.
	Р	ract/Fratern Term Life Policy				PDF
		al				
		Certificate				
	SLTL1400I	Application/Enrollment Form	Initial		56	SLTL1400IE.
	Е	Enrollment				PDF
		Form				

## STONEBRIDGE LIFE INSURANCE COMPANY

#### A STOCK COMPANY

Home Office: Rutland, Vermont

Administrative Office: [2700 West Plano Parkway, Plano, Texas 75075]

Toll Free Number[1-800-527-9027]

#### SCHEDULE OF INSURANCE

INSURED:			FACE AMOUNT: \$
POLICY NUMBER:		EFFECTIVE DATE:	EXPIRATION DATE:
AGE AT ISSUE:	SEX:	ISSUE DATE:	

Stonebridge Life Insurance Company (herein called "we," "our," or "us") has issued this Policy to the Insured shown in the Schedule which provides non-renewable, term life insurance for a term of 12 months.

We agree to pay the benefits provided with respect to the Insured (herein called "you", "your" or "yours"), subject to the terms of this Policy.

This Policy supersedes any Policy previously issued to you. You may qualify under one Policy only during any one 12-month period. If you are insured under more than one Policy, we will consider you to be insured under the Policy which provides the greatest amount of coverage. Upon discovery of the duplication, we will refund any payments which may have been made on your behalf.

**YOUR RIGHT TO EXAMINE THE POLICY:** You may return this Policy for any reason within [30] days of the date you receive your Policy. The Policy is treated as if it never existed. No benefits are paid.

TO OBTAIN INFORMATION OR TO MAKE A COMPLAINT: You may call our toll-free telephone number at [1-800-732-1821.]

#### **PART I – DEFINITIONS**

**POLICY EFFECTIVE DATE** means the date your coverage starts, as shown on the Schedule of Insurance, provided you are alive on that date.

**INSURED** means you, the Insured named on the Schedule of Insurance, who is eligible for coverage and whose coverage has become effective.

LOSS means loss of life.

#### PART II -WHEN COVERAGE STARTS AND STOPS

**WHEN COVERAGE STARTS** – Your coverage takes effect, after we receive your enrollment form, on the Policy Effective Date shown on the Schedule of Insurance, and while you are alive.

**WHEN COVERAGE STOPS** – Coverage stops on the earliest of a) the Expiration Date stated on the Schedule of Insurance; or b) the date of your death.

#### PART III - WHAT BENEFITS WE PAY

**AMOUNT OF COVERAGE** – We pay the Face Amount when you die while covered under this Policy. The Face Amount is shown on the Schedule of Insurance. Before we pay, we must be given proof of loss. **SUICIDE** – A benefit will not be paid if Loss is a result of suicide, whether sane or insane.

# INDIVIDUAL 12-MONTH TERM LIFE INSURANCE POLICY NON-CONTRIBUTORY – NON PARTICIPATING –NON RENEWABLE

#### PART IV - WHO RECEIVES THE BENEFITS

**BENEFICIARY:** At your death, unless you specify otherwise, any benefit for loss of life will be paid to your then living lawful spouse; otherwise equally to your then living lawful children, if any; otherwise equally to your then living parents or parent, otherwise to your estate. Any payment made under this section will fully release us to the extent of the payment. (For **WISCONSIN** residents, if there is no beneficiary when you die, benefits are paid to your estate.)

**CHANGING THE BENEFICIARY:** You can change your beneficiary at any time by writing to us at our Administrative Office. Once we record the change, it will take effect as of the day you signed the request, subject to any claim payment made before such recording. The consent of the beneficiary is not needed for the change, unless the beneficiary designation was irrevocable. (For **WISCONSIN** residents: permanent Beneficiary is changed to irrevocable Beneficiary)

#### PART V - PAYMENT OF PREMIUMS

**PREMIUMS:**. The premium due by the terms of the Policy shall be payable in advance either at our Administrative Office or to an agent of the company upon delivery of a receipt signed by one or more of the officers who are designated in the Policy. The premium due is paid by [Mother's Work Services, Inc.]. The premium will be based on our rates in effect for the Policy on the date such premium is due.

#### **PART VI - GENERAL PROVISIONS**

- **A. INCONTESTABILITY:** This policy is issued in consideration of the enrollment form and payment of the premiums. This Policy is "incontestable" from its Effective Date (Issue Date for **MASSACHUSETTS** residents), subject to the "Misstatement of Age" provision. "Incontestable" means we may not deny benefits except for non-payment of premiums when due. All statements made in the enrollment form, in the absence of fraud, will be deemed representations and not warranties. No statement will be used to void this policy or be used in defense of a claim unless it is in the enrollment form.
- **B. ENTIRE CONTRACT:** The policy and the copy of the enrollment form attached to it form the entire contract. No change in this Policy is effective until approved by one of our officers. Such approval must be noted on or attached to this Policy. No agent has the authority to change this policy or waive any of its provisions.
- **C. MISSTATEMENT OF AGE:** If your age has been misstated, the benefits will be those which the premiums paid would have bought for the correct age.
- **D. PROOF OF LOSS:** A certified copy of the death certificate showing the date and cause of death must be given to us before payment of death claim will be made. Failure to give proof of Loss on a timely basis will not by itself result in denial of the claim for the Loss unless failure makes it impossible to investigate the claim properly or otherwise prejudices us.
- **E. TIME PAYMENT OF CLAIMS:** We will pay all benefits covered under the Policy as soon as we receive proper Proof of Loss sufficient to determine liability.
- **F. INTEREST AT SETTLEMENT:** If required, we pay interest on death proceeds according to the requirements of your state. The rate of interest is not less than that required by law. (For **VERMONT** residents, the rate of interest is equal to the rate of interest on proceeds left on deposit with us or 6 percent, whichever is greater at the time the benefit is paid.)
  - FOR **NEVADA** RESIDENTS ONLY: We must pay the benefit within 30 days after the date of your death. If we fail to do so, we pay interest on the death benefit. It is accrued from: (1) the date of death until (2) the date we make payment. The rate of interest is equal to the rate of interest on death proceeds left on deposit with us.
  - FOR **NORTH DAKOTA** RESIDENTS ONLY: We must pay the benefit within two months after we are given proof of death. We must also pay reasonable interest on the death benefit. It is accrued from: (1) the date of death; until (2) the date we make payment. This is paid so long as we are given proof of death within 180 days after the date of death. Reasonable interest is the rate of interest paid on proceeds left on deposit with us.
  - FOR **OREGON** RESIDENTS ONLY: We have 30 days from the date we receive due proof of death to pay the death benefit. If we delay payment beyond this 30 day period we will pay interest. The current rate of interest is set by Oregon law. It is paid from: (1) the date of your death; until (2) the date we make payment. If we do not

pay during this 30 day period we will notify the Beneficiary that we will pay interest. If we do pay during the 30 day period, no interest is paid.

FOR **TEXAS** RESIDENTS ONLY: We must pay the benefit within two months after we are given proof of death. We must also pay interest on the death benefit. It is accrued from: (1) the date we receive proof of death; until (2) the date we make payment. The rate of interest is equal to the rate of interest on proceeds left on deposit with us.

FOR **UTAH** RESIDENTS ONLY: We must pay the benefit within 15 days from the date we receive due proof of death.

FOR **WYOMING** RESIDENTS ONLY: We must pay the benefit within 45 days after we are given proof of death. We must also pay interest on the death benefit. It is accrued from: (1) the date of death; until (2) the date we make payment. The rate of interest is equal to the rate of interest on proceeds left on deposit with us.

- **G. PAYMENT OF CLAIMS:** Benefits are payable in accordance with the beneficiary designation in effect at the time of payment.
- H. AUTOPSY: At our expense, we may have an autopsy done where it is not forbidden by law.
- LEGAL ACTIONS: No action can be brought to recover on the Policy for at least 60 days after written Proof of Loss has been furnished. No such action shall be brought more than 3 years after the date Proof of Loss is required.
- **J. NON-PARTICIPATING:** There are no dividends payable under this Policy. It does not share in our surplus earnings.

Marilyn Carp President

IN WITNESS, this Policy is signed by our President and Secretary.

Craig D. Vermes

SLTL1400IP Page 3 of 3 [GXXX]

# INDIVIDUAL TERM LIFE INSURANCE ENROLLMENT FORM

# Yes

# Please enroll me for this 12-Month Term Life Insurance Protection for a benefit amount of [\$10,000]

<ol> <li>I understand that in order to enroll for this coverage, I, the apple of [Mother's Work Services, Inc.];</li> <li>be between the ages of [[18] through [49]], and reside the offered;</li> <li>be pregnant at the time of enrollment.]</li> </ol>	
Name	Insured's Date of Birth/
Address	Insured's Date of Birth/ mo day yr [Gender Female Male]
City, ST ZIP Code	Home Telephone # ( )
[Beneficiary designation: Unless you specify below, benefit for spouse; otherwise equally to your then living lawful children, if or parent, otherwise to your estate.]  Beneficiary	
I understand that this coverage will be provided [at no cost to my enrollment form [[is] [and premiums of \$X.XX are]] receiv	
and will be effective on the date stated on the Schedule of Institute of this enrollment form as it applies to my state of reside	surance. [I have read the fraud notice [below][on the
X	Date / /
Insured's Signature - Required	Date// month day year
Stonebridge Life Insura Home Office: Rutland, Vermont /Administrative Offices: [276]	
SLTL1400IE	

[Residents of ARKANSAS, NEW MEXICO, and OHIO: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.]

[Residents of DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.]

[Residents of FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.]

[Residents of KENTUCKY: Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement or claim containing any false, incomplete, or misleading information is guilty of a felony.]

[Residents of LOUISIANA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[Residents of MAINE and TENNESSEE and WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.]

[Residents of MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

[Residents of NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

[Residents of NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.]

[Residents of PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

SERFF Tracking Number: AEGX-125987244 State:

Filing Company: State Tracking Number: 41336

Company Tracking Number: TL AR0045615C01

TOI: L041 Individual Life - Term Sub-TOI: L041.003 Single Life - Single Premium

Arkansas

Product Name: Term Life

Project Name/Number: Term Life/TL AR0045615C01

### **Rate Information**

Rate data applies to filing.

Filing Method: Prior Approval

**Rate Change Type:** 

**Overall Percentage of Last Rate Revision:** 

**Effective Date of Last Rate Revision:** 

Filing Method of Last Filing:

# **Company Rate Information**

Company Name:	Overall %	Overall % Rate	Written	# of Policy	Premium:	Maximum %	Minimum %
	Indicated	Impact:	Premium	Holders		Change (where	Change (where
	Change:		Change for	Affected for this		required):	required):
			this	Program:			
			Program:				
Stonebridge Life	%	%				%	%

Insurance Company

SERFF Tracking Number: AEGX-125987244 State: Arkansas
Filing Company: Stonebridge Life Insurance Company State Tracking Number: 41336

Company Tracking Number: TL AR0045615C01

TOI: L041 Individual Life - Term Sub-TOI: L041.003 Single Life - Single Premium

Product Name: Term Life

Project Name/Number: Term Life/TL AR0045615C01

# **Supporting Document Schedules**

**Review Status:** 

Satisfied -Name: Explanation of Variability 01/13/2009

Comments: Attachment:

Explanation of Variability.PDF

**Review Status:** 

Satisfied -Name: AR - CONSENT TO SUBMIT 01/13/2009

RATES AND/OR COST BASES FOR APPROVAL, AR - NAIC TRANSMITTAL DOC, AR - NAIC FORM FILING ATTACHMENT

**Comments:** 

Attachments:

AR - CONSENT TO SUBMIT RATES AND\_OR COST BASES FOR APPROVAL.PDF

AR - NAIC TRANSMITTAL DOC.PDF

AR - NAIC FORM FILING ATTACHMENT.PDF

**Review Status:** 

Satisfied -Name: Flesch Certification 01/13/2009

Comments: Attachment:

AR - READABILITY CERTIFICATION.PDF

#### **Explanation of Variable Items**

#### Form SLTL1400IP - Individual Term Life Insurance Policy

#### Page 1

\* Administrative Office address and Toll Free telephone number will appear as shown. These items may vary depending on the location and phone number of the office that will administer the policy.

#### Page 1

#### **Policy Schedule Data**

\* The INSURED, FACE AMOUNT, POLICY NUMBER, EFFECTIVE DATE, EXPIRATION DATE, AGE AT ISSUE, SEX, and ISSUE DATE schedule items will vary to reflect the individual insured's policy information.

#### Page 1

#### **Right to Examine Provision**

\* The number of days in the Right to Examine provision may be [30], [60] or [90] days as approved by the Company to be offered under a program of insurance.

#### Page 2

#### Part V – Payment of Premiums

\* The name of the entity that is contracted with the Company to offer the policy to its customers and/or members and pay premiums will appear here.

#### **Footer**

#### Administrative Form Number - Bottom Right Corner

When indicated for a specific administrative system, the number assigned for a program of insurance approved by the Company and will be used to identify that program with respect to the applicable variables described in this statement.

#### Form SLTL1400IE - Individual Term Life Enrollment Form

#### **Amount of Insurance**

\* The amount of insurance that is approved by the Company to be offered under a program of insurance may be an amount between [\$5,000] and [\$20,000].

#### Conditions for enrollment eligibility

- \* The conditions for determining eligibility of the insured will appear as shown, or may be removed if they are not applicable for the coverage offered and approved under the policy.
- \* The member definition and maximum age will vary consistent with that of the coverage offered and approved under the policy.

#### Beneficiary definition

\* The definition is variable and will be printed as shown or may be removed in its entirety.

#### Cost of coverage

\* The paragraph will be printed with the text as shown to describe coverage offered at no cost to the insured or coverage provided at a stated cost as offered and approved under the policy.

#### **Fraud Warning**

- \* The sentence regarding the fraud notice appearing on the back of the enrollment may be removed when coverage is offered to residents of a state where the requirement would not apply.
- \* The corresponding Fraud Warning paragraph appearing on the back of the enrollment form will appear as shown or may each be removed in their entirety when coverage is offered to residents of a state where the requirement would not apply.

# **STATE OF ARKANSAS**

# Certification

Name of Company: Stonebridge Life Insurance Company					
The above named company certifies that Individual 12-Month Term Life Policy					
Form No. SLTL1400IP has been reviewed and complies with Arkansas					
nsurance Department Guidelines identified in its Bulletin No. 11-83.					
Cally L. up					
Signature					
Cathy L. Wynn					
Print or Type Name					
Filing Specialist					
Title					

# **STATE OF ARKANSAS**

# Certification

Name of Company: Stonebridge Life Insurance Company
The above named company certifies that Enrollment Form
Form No. SLTL1400IE has been reviewed and complies with Arkansas
Insurance Department Guidelines identified in its Bulletin No. 11-83.
Arthur
Cathy R. up
Signature
Cothy L. Myron
Cathy L. Wynn
Print or Type Name
Filing Specialist
Title

# Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of Arkansas									
	Department Use Only									
2.	State Tracking ID		De	par unent Osc	On	ıy				
3.	Insurer Name & Address		Domicile	Insurer License Type		NAIC Group # NA		AIC#	FEIN#	State #
29 So	bridge Life Insurance Company uth Main Street nd VT 05701-5014		VT	L&H		468	6	55021	03- 0164230	
4.	Contact Name & Address		Telephone	#	Fa	x #		E-mai	l Address	
Cathy 400 C	L. Wynn, HIA, FLMI, ACS, Alballeria Parkway, Suite 1000 ta GA 30339	LHC	800-521-10			8-402-2105			@aegonusa.c	om
5.	Requested Filing Mode	Review & Approval								
6.	Company Tracking Number	TL AR	0045615C01							
7.	New Submission		ıbmission	Previous file	e #					
			Individual	Franc	hise	<del></del>				
8.	Market	Gro	Group Small Large Small and Large    Employer							
9.										
10.	Product Coding Matrix									
11.	Submitted Documents		RATES New Ra FILING OF Please expl	THER THAN Dain:  DOCUMENT ncorporation Bylaws f Variability	sed	RM OR RATE:	earty gre	Author		

LH TD-1, Page 1 of 2 © 2007 National Association of Insurance Commissioners

12.	Filing Submission Date	01/13/2009
	Elina Ess	Amount Check Date
13.	Filing Fee (If required)	Retaliatory
14.	Date of Domiciliary Approval	
15.	Filing Description:	
	approval. This form is new and is not The Product will not be illustrated.  The policy provides term life insurar amount in the event of death due to a The single premium is non-contribut issued on a guaranteed issue basis. Is Bracketed information throughout the document.  The product will be marketed via diran electronic signature process for the	surance Policy - SLTL1400IP 00IE  surance policy and related material is submitted for your departmental review and of intended to replace any previously approved form.  see. The death benefit is level for a period of 12 consecutive months and pays the face any cause.  ory and payable by the entity named in the premium payment provision. The policy is
16.	Certification (If required)	
I HE		d the applicable filing requirements for this filing, and the filing complies with all ons for the state of Arkansas.
Print ?	Name Cathy L. Wynn, HIA, FLMI,	ACS, ALHC Title Filing Specialist
Siana	Cathy L. up	Date 01/13/2009

LH TD-1, Page 2 of 2 INS11799

17.	Form Filing Attachment				
This f	iling transmittal is part of company tracking number	TL AR0045615C01			
This f	iling corresponds to rate filing company tracking number				

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Individual 12-Month Term			
	Life Policy	CI TI 1400ID	Revised	
		SLTL1400IP	Other	
02	Enrollment Form			
	Enrollment Form	SLTL1400IE	Revised	
		SLILI400IE	Other	
03			☐ Initial	
			Revised	
			☐ Other	
04			☐ Initial	
			Revised	
			☐ Other	
05			Initial	
			Revised	
			☐ Other	
06			Initial	
		<u> </u>	Revised	
			Other	
07			Initial	
			Revised	
			Other	
08			Initial	
08			Revised	
		4		
09			Initial	
0)			Revised	
		†	Other	
10			Initial	
			Revised	
			Other	
11			☐ Initial	
			☐ Revised	
			☐ Other	

#### STATE OF ARKANSAS

#### READABILITY CERTIFICATION

**COMPANY NAME:** Stonebridge Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score	
SLTL1400IP	59.4	
SLTL1400IE	55.8	

Sig	ned:	

Name: Edward Wiegand
Title: Assistant Secretary

Date: 01/13/2009